

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11697

## 11703 CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Queen Anne's MARYLAND		Md. Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Queenstown	35 yrs.	Queenstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
George Washington Aldridge	—		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
George	W	Washington	Aldridge
4. DATE OF DEATH	Month	Day	Year
Oct.	29		1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	W	Dec. 4, 1894	9. AGE (In years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Clerical		—	Md.
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
George W. Aldridge	Margaret Frances Keating		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	W.W. I	218-03-5854	Mrs. Helen Aldridge - Queenstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
527.1			
DUE TO			
Pulmonary Embolism			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
Cor Pulmonale			
DUE TO			
(c) Obstructive Emphysema			
INTERVAL BETWEEN ONSET AND DEATH			
20 yrs.			
35 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year			
Hour	o. m.	19	20d. INJURY OCCURRED
p. m.			While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1951, to Oct. 1958, that I last saw the deceased alive on Oct. 29, 1958, and that death occurred at 4:40 P.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
ACTUAL SIGNATURE			
Loring G. Hoyt M.D.			
PHYSICIAN'S NAME (Type)			
Loring G. Hoyt			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
Burial		Nov 1-1958	Old Loge Church
22d. LOCATION (City, town, or county)		(State)	
Loge Mill, Maryland		Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
Edward Rector, Jr., B.C.P.		Chestertown, Maryland	NOV 3 '58
DATE		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Evans	

## FORM - CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11704

## CERTIFICATE OF DEATH

11698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Centreville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Centreville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Annie	Middle E.	Last Beaver	4. DATE OF DEATH Oct.	Month 26	Day 19	Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1867		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Dawkins		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Beaver, Centreville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434,4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		(b) DUE TO		(c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Centreville, Md.	(County)	(State)			
21. I certify that I attended the deceased from <u>Aug 15</u> , 1958 to <u>Oct 26</u> , 1958, that I last saw the deceased alive on <u>Oct 25</u> , 1958, and that death occurred at <u>M</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Centreville, Md.		DATE SIGNED 10/27/58			
ACTUAL SIGNATURE W. Henry Fisher	PHYSICIAN'S NAME (Type) W. Henry Fisher		Centreville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 28	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn	22d. LOCATION (City, town, or county) Easton, Maryland	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane	ADDRESS Church Hill, Md.	24a. REC'D BY REGISTRAR OCT 29 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus						

## DEPARTMENT OF HEALTH - BALTIMORE CITY

## CERTIFICATE OF DEATH

1910-1911

Name of deceased

Cause of death

Name of physician

Name of hospital

Name of funeral home

Name of coroner

Name of medical examiner

Name of pathologist

Name of laboratory

Name of coroner

Name of medical examiner

Name of pathologist

Name of laboratory

Name of coroner

Name of medical examiner

Name of pathologist

Name of laboratory

Name of coroner

Name of medical examiner

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Name of coroner

Name of medical examiner

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Name of laboratory

Name of coroner

Name of medical examiner

Name of pathologist

Name of laboratory

Name of coroner

Name of medical examiner

Name of pathologist

Name of laboratory

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11705 CERTIFICATE OF DEATH

11699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RURAL STEVENSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RURAL STEVENSVILLE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year	
FEM.	FLORENCE	MAY	Bowen	Oct.	8 1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	
WIDOWED <input checked="" type="checkbox"/>	WHITE	DIVORCED <input type="checkbox"/>	MAY 31 - 1879	79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE		MARYLAND	USA			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
JAMES H. CARMINE	MARGARET FRAMPTON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
(If yes, give war or dates of service)		Mrs. Paul Palmer - Stevensville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	about 8 months					
157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.	about 6 months					
DUE TO (b) obstructive jaundice						
DUE TO (c) arteriosclerosis + essential hypertension + years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
cholecysto-jejunostomy May 15, 1958.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from alive on Oct. 7, 1958, and that death occurred at 6 P.M., from the causes and on the date stated above.	Oct. 8, 1958					
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)					DATE SIGNED
PHYSICIAN'S NAME (Type)	Stevensville					Oct. 9, 1958.
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORI	22d. LOCATION (City, town, or county)	(State)		
BURIAL	Oct. 10	STEVENSVILLE	STEVENSVILLE	MD.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE			
Edgar D. Lane - Church Hill, Md.		DATE OCT 14 '58	Arthur S. Khan			

## CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11700

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dress Annex</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>N. Carolina</i> b. COUNTY <i>? 70x3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severnville</i>		c. LENGTH OF STAY IN 1b <i>few hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Robert</i>	Middle <i>James</i>	Last <i>Bristow</i>
4. DATE OF DEATH	Month <i>Oct</i>	Day <i>13</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13-1921</i>
9. AGE (In years last birthday) <i>37</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Filling Station Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Montgomery Co N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Oscar L. Bristow</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Lee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <input checked="" type="checkbox"/> <i>World War II</i>		16. SOCIAL SECURITY NO. <i>811-12-1212</i>	
17. INFORMANT PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Address <i>Fayetteville N.C. 2009 Oakleaf Drive</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>	Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Deary North Carolina</i> (County) <i>(State)</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. Stevens Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>W. Stevens Fisher</i>	DATE SIGNED <i>10/13-58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 16-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Southside</i>	22d. LOCATION (City, town, or county) <i>Deary North Carolina</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Bush of Bush Bros Entombed Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>OCT 15 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Charles L. Green</i>

STATE OF CALIFORNIA  
REGISTRATION OF DEATHS

REGISTRATION

DEATH CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Item 20 Film 235 10-22-58 <sup>ans</sup> MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Queen Anne	
Rural Queen Anne		2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
NAMES		DUDLEY CALLAHAN		Month Oct. Day 11 Year 1958	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 8, 1952	
9. AGE (In years last birthday) 6 yrs.		9. IF UNDER 1 YEAR Months		10. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Herman Callahan Jr.		14. MOTHER'S MAIDEN NAME Jean Reddery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X Fractured knee - broken neck				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO			
		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) He was riding on fender of truck & jumped off & fell backward under truck wheel & truck ran over his head & broke neck			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte 309	
Oct 11 1958				(City or town) (County) (State) Queen Annes Co.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE W. Henry Faslee		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/13/58	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Hillsboro	
22d. LOCATION (City, town, or county) Hillsboro				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 17 '58	
John Vogel his over son J. L. G. J. L. G.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF MASSACHUSETTS  
DEPARTMENT OF PUBLIC HEALTH

DEATH CERTIFICATE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11708

## CERTIFICATE OF DEATH

11702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Queen Anne		c. LENGTH OF STAY IN 1b 17 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural— Queen Anne				
3. NAME OF DECEASED (Type or print) William		First Middle Lost Walter Covington	4. DATE OF DEATH October			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Month Day Year Nov. 29, 1917 26 19 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME W. D. Wilkes Covington		14. MOTHER'S MAIDEN NAME Lydia Mae Anders				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 36 0070	17. INFORMANT Mrs. Elizabeth Barton Covington, RD, Md.			
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Address Queen Anne, Ridgeley, Md.				
		INTERVAL BETWEEN ONSET AND DEATH 15 min				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19				
		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hillsboro	(County) Maryland	(State)
21. I certify that I attended the deceased from <u>October, 1956</u> , to <u>October 2, 1958</u> , that I last saw the deceased alive on <u>Oct. 2</u> , 1958, and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 10.27.58		
ACTUAL SIGNATURE CHARLES H. WINNACOTT M.D.						
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery	22d. LOCATION (City, town, or county) Hillsboro, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. F. F. Carroll		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DAECT 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 11709 CERTIFICATE OF DEATH

11703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Queen Anne's MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		b. COUNTY	
Chester		Q. A.	
c. LENGTH OF STAY IN 1b 3 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harbor Drive		d. STREET ADDRESS Harbor Drive Chester Md	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Mary		Ann	Harrison
4. DATE OF DEATH		Month	Day
10		-	3
Year		1958	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	8. DATE OF BIRTH April 30, 1873
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
75 yrs.		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Julius Wilson Sass		14. MOTHER'S MAIDEN NAME Mary Schenm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. RECE Robert D. Lehunt	
17. INFORMANT Address Chester, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalised Atherosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days. ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1</u> , 1958, to <u>Oct 3</u> , 1958, that I last saw the deceased alive on <u>Oct 3</u> , 1958, and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Irvin F. Hoyt</u> M.D.		DATE SIGNED <u>10/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-58	22c. NAME OF CEMETERY OR CREMATORIAL Western Cem.
22d. LOCATION (City, town, or county) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE McCullly Funeral Homes 130 E. Fort St Baltimore 30		24a. REC'D BY REGISTRAR OCT 7 1958	24b. REGISTRAR'S SIGNATURE Irvin F. Hoyt

1970 CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18-20 Film 235 10-29-58 a.m.s

11704

11710

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevensville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Stevensville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <i>DEBORAH</i>		First <i>ANN</i>	Middle <i>HOXTON</i>			
4. DATE OF DEATH <i>Oct. 17 1958</i>		Last <i>HOXTON</i>	Month <i>Oct.</i>			
5. SEX <i>Fem</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 26-1866</i>			
9. AGE (In years last birthday) <i>92 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>WM. KERSEY</i>	14. MOTHER'S MAIDEN NAME <i>HARRIETT TOLSON</i>	Address <i>Mrs. Wm. Hoxton = Stevensville</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>332X</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Wm. Hoxton = Stevensville</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>Arteriosclerosis general + cerebral</i> DUE TO Fractured left femur	INTERVAL BETWEEN ONSET AND DEATH <i>Oct. 15. 1958</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>9049 bronchopneumonia 8 years ago</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on front porch at home</i>	20c. TIME OF INJURY Hour a. m. <i>5</i>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>	20f. (City or town) <i>Stevensville</i>	(County) <i>QA</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Oct. 15 1958</i> to <i>Oct. 17 1958</i> , that I last saw the deceased alive on <i>Oct. 17 1958</i> , and that death occurred at <i>7:30 p.m. Oct. 17 1958</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Theodor Sattelmaier M.D.</i>	PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAIER</i>	ADDRESS (Street, city or town, state) <i>Stevensville Md. Oct 18 1958.</i>	DATE SIGNED <i>Oct 18 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 20</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>STEVENSVILLE</i>	22d. LOCATION (City, town, or county) <i>STEVENSVILLE MD.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Lavel Church Hill</i>	ADDRESS <i>Edgar S. Lavel Church Hill</i>	24a. REC'D BY REGISTRAR <i>DA 10/22/58</i>	24b. REGISTRAR'S SIGNATURE <i>Edgar S. Lavel</i>			

## CERTIFICATE OF DEATH

DEATH CERTIFICATE

DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 11711 CERTIFICATE OF DEATH

11705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
Queen Anne MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) church Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Church Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
Tem.		Eva	Spry
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Retired School Teacher			Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John L. Spry		Mary Cahoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
			J. Milton Hunter--Church Hill, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
159.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Carcerous & Ch. Dilemma	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 14</u> , 1957, to <u>Oct. 15</u> , 1958, and that death occurred at <u>Oct. 15</u> , 1958, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED Baltimore Md. 10/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18	22c. NAME OF CEMETERY OR CREMATORIAL Chesterfield
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill Md.	24a. REC'D BY REGISTRAR DATE OCT 21 '58
			24b. REGISTRAR'S SIGNATURE Arthur S. Evans

## CERTIFICATE OF DEATH

DEATH DATE

DEATH PLACE

DEATH CAUSE

DEATH TIME

DEATH AGE

DEATH GENDER

DEATH RACE

DEATH RELIGION

DEATH OCCUPATION

DEATH MARRITAL STATUS

DEATH EDUCATION

DEATH MIGRATION STATUS

DEATH MIGRATION DURATION

DEATH MIGRATION DESTINATION

DEATH MIGRATION REASON

DEATH MIGRATION DATE

DEATH MIGRATION VEHICLE

DEATH MIGRATION VEHICLE NUMBER

DEATH MIGRATION VEHICLE OWNER

DEATH MIGRATION VEHICLE OWNER ADDRESS

DEATH MIGRATION VEHICLE OWNER PHONE

DEATH MIGRATION VEHICLE OWNER EMAIL

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DEATH MIGRATION VEHICLE OWNER EMAIL

DEATH DATE

DEATH PLACE

DEATH CAUSE

DEATH TIME

DEATH AGE

DEATH GENDER

DEATH RACE

DEATH RELIGION

DEATH OCCUPATION

DEATH MARRITAL STATUS

DEATH EDUCATION

DEATH MIGRATION STATUS

DEATH MIGRATION DURATION

DEATH MIGRATION DESTINATION

DEATH MIGRATION REASON

DEATH MIGRATION DATE

DEATH MIGRATION VEHICLE

DEATH MIGRATION VEHICLE NUMBER

DEATH MIGRATION VEHICLE OWNER

DEATH MIGRATION VEHICLE OWNER ADDRESS

DEATH MIGRATION VEHICLE OWNER PHONE

DEATH MIGRATION VEHICLE OWNER EMAIL

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DEATH MIGRATION VEHICLE OWNER ADDRESS

DEATH MIGRATION VEHICLE OWNER PHONE

DEATH MIGRATION VEHICLE OWNER EMAIL

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11712

## CERTIFICATE OF DEATH

11706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Queen Anne's MARYLAND		Md. Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Centreville		c. LENGTH OF STAY IN 1b 80+ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Centreville	
e. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH First Middle Last Month Day Year	
Fanny Morris Jackson Oct 31 1958		5. SEX	
F		6. COLOR OR RACE	
C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) 82 yrs.	
Jan. 30, 1876		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Morris		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT 219-05-0281 Burton Jackson - Centreville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1		Carcinoma of the Liver	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
260x		Diabetes Mellitus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1957 to Oct. 1958 that I last saw the deceased alive on Oct. 27, 1958, and that death occurred at 3:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Luis D. Hoyt M.D.		DATE SIGNED 10/31/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 3-1958	
22c. NAME OF CEMETERY OR CREMATORIAL Brownsville		22d. LOCATION (City, town, or county) In Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Burton, Burton Brothers Centreville Maryland		24a. REC'D BY REGISTRAR DATE NOV 3 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health as its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M 00 00 I 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Penns</u> b. COUNTY <u>Phila</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Millington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2120 S. 15th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret J. Newsham</u>		4. DATE OF DEATH <u>Oct. 26</u>	Month <u>Oct.</u> Day <u>26</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13 1888</u>
9. AGE (In years last birthday) <u>70 yrs.</u>		10. IF UNDER 1 YEAR <u>Months</u>	11. IF UNDER 24 HRS. <u>Days</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>wore retired mail clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Private Person</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Robert Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>162-10-3962 (daughter)</u>	
17. INFORMANT <u>Mrs. Ectore</u>		Address <u>213 (Country Club Rd.) Brookdale Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Found dead in bed - has had hypertension</u>			
DUE TO <u>for several years</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u></u>			
DUE TO <u></u>			
(c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Yealm, Pa. Co. Penns</u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u></u>		DATE SIGNED <u>10/26/58</u>	
22a. BURIAL, CREMATION, OR MAINTAIN (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) <u>Yealm, Pa. Co. Penns</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellour Millington Md.</u>		24a. REC'D. BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kress</u> DATE <u>OCT 28 '58</u>	

STATE OF NEW YORK  
EXAMINER OF DEATH

STATE OF NEW YORK  
EXAMINER OF DEATH

1

- Autopsy
- Death certificate
- Death report
- Death record
- Death registration
- Death report
- Death record
- Death registration

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 20 State Med. Exam. 11-26-58 a.m.s  
1171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11708

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transtil permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		c. LENGTH OF STAY IN 1b <u>all his life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Geo</u>	Middle <u>W</u>	Last <u>Person</u>
4. DATE OF DEATH	Month <u>Oct</u>	Day <u>26</u>	Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30 - 1899</u>
9. AGE (In years last birthday) <u>69 yrs.</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			11. BIRTHPLACE (State or foreign country) <u>Grasonville Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Morgan Person</u>
14. MOTHER'S MAIDEN NAME <u>Darina Hassett</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. <u>219-03-4108</u>			17. INFORMANT <u>Mrs Clyde Callier - Grasonville Md</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>(a) Auto accident - Head injury</u>			
812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(b)</u>			
DUE TO <u>(c)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-Pedestrian; was crossing State Highway</u>	
20c. TIME OF INJURY Hour <u>1:15</u> a.m.	Month, Day, Year <u>10/26 19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Highway</u>
20f. (City or town) <u>Queenstown</u>	(County) <u>QA</u>	(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>	DATE SIGNED <u>10/27-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 28-58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Chesapeake</u>	22d. LOCATION (City, town, or county) <u>Chesapeake Maryland</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Batten &amp; Sons Cemetery Md</u>	ADDRESS	24a. REC'D BY REGISTRAR <u>Oct 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hause</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 11715 CERTIFICATE OF DEATH

11709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Queen Anne's MARYLAND		Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Centreville		c. LENGTH OF STAY IN 1b 18 mo.					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Centreville		d. COUNTY Q. A.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emma		First	Middle				
4. DATE OF DEATH		Last	Month				
5. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH	8. AGE (In years lost birthday) Nov. 26, 1894 63 yrs.	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lizzie Square					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT none Robert Whittington - Centreville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1958, to Oct 14, 1958, that I last saw the deceased alive on Oct 13, 1958, and that death occurred at 12:30 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 10/14/58	
ACTUAL SIGNATURE Irvin E. Hoyt				M.D.		Irvin E. Hoyt MD	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Oct 18-1958		22c. NAME OF CEMETERY OR CREMATORIAL Venton		22d. LOCATION (City, town, or county) Queen Anne Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Bunting Bunting Bros Centreville Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE Howard Bunting	

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